CITY OF LONG BEACH
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Referral Date: ____________

Language: ____________

CAR SEAT CHECK-UP

REFERRAL

Child's Last Name: ______________________________ First: ______________________________
DOB or anticipated: ________________ Height: __________________ Weight: __________________
Special Needs: ____
Current car seat (make/model/year) or none: ____

Child's Last Name: ______________________________ First: ______________________________
DOB or anticipated: ________________ Height: __________________ Weight: __________________
Special Needs: ____
Current car seat (make/model/year) or none: ____

Child's Last Name: ______________________________ First: ______________________________
DOB or anticipated: ________________ Height: __________________ Weight: __________________
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DOB or anticipated: ________________ Height: __________________ Weight: __________________
Special Needs: ____
Current car seat (make/model/year) or none: ____

Child's Last Name: ______________________________ First: ______________________________
DOB or anticipated: ________________ Height: __________________ Weight: __________________
Special Needs: ____
Current car seat (make/model/year) or none: ____

Parent's Last Name: ______________________________ First: ______________________________
Address: ____
Phone: ______________________________ E-mail: ______________________________

Primary Vehicle (Make/Model/Year): ____
Secondary Vehicle (Make/Model/Year): ____

Reason for Referral/Notes: ____
____
____

Referred by (Name & Organization): ____

Return this referral

E-mail: Morgan.Venter@LongBeach.gov **Fax: (562) 570-4099**

1/2017